Exhibit A9

1 FLN/DCC 0917731729973 SSN: [redacted] SOURCE INDICATOR 6 VENDOR ID EN HOSPITAL BILLING DATE 06/26/09
PROCESS DATE: 06 26 09 PAYER ID: 87726 RTE IND: ATTCH: KEYER: 111111999 DT: 06 26 09

PROVIDER NAME: AMBULATORY HEALTH SYSTEMS PROVIDER TEL:	EMC OFFICE NO: 0000
PROVIDER ADDRESS: 8409 PICKWICK LN, STE 238 PROVIDER SUB ID:	
PROVIDER CITY: DALLAS ST: TX ZIP CODE: 75225	
FAX NUM: COUNTRY CD: NPI: 1194986604	

HEALTH PLAN ID:	
MEDICARE PROVIDER NO:	
MEDICAID PROVIDER NO:	
BLUE CROSS NO:	
FEDERAL TAX ID: 262791218	

PATIENTS NAME:
[redacted]

PATIENT CNTRL NO: [redacted]	PATIENT SEX: F PATIENT DOB: [redacted]	PAT MARITAL STAT:	
MEDICAL REC NO: 924	PAT EMPL STAT:		
1PAYER NAME: UNITED HEALTHCARE(METRAHE	INSURED NAME: [redacted]	PRIOR PAY AMT:	0.00
SSN: [redacted]	INSURED SEX:	PAT REL: SPOUSE	
GROUP NAME:	POLICY NO: 702227	ASSIGN BEN: Y	
2PAYER NAME:	INSURED NAME:	PRIOR PAY AMT:	0.00
SSN:	INSURED SEX:	PAT REL:	
GROUP NAME:	POLICY NO:	ASSIGN BEN:	
CLAIM FILING INDICATOR:	ICN/DCN NUMBER:		
3PAYER NAME:	INSURED NAME:	PRIOR PAY AMT:	0.00
SSN:	INSURED SEX:	PAT REL:	
GROUP NAME:	POLICY NO:	ASSIGN BEN:	
CLAIM FILING INDICATOR:	ICN/DCN NUMBER:		

TYPE BILL: SPEC FACIL/AMB SURG C/ADM-DSCH CL CD: 831 MOST COMM SEMIPVT RATE: PROC CD METHOD:

LINE #	REV CODE	RATE/ DATE	DESCRIPTION OR SERVICES	DAYS/ UNITS	CHARGE	HIC PIC	MOD1	MOD2
001	0360	04/01		1	6500.00	58563		

MOD CODE: DESCRIPTION

AMT PAT PAID:	EST AMT DUE:	TOT CHARGE:	AMOUNT DUE:
0.00	0.00	6500.00	6,500.00

TREATMENT AUTH NOS:

STATMNT COV PER FROM: 04/01/09 THRU:

ADMISSION DATE: ADMISSION HOUR: DRG CD: 000

PAT STATUS CD: PAT STATUS: DSCHG HR: COV DAYS: 0 NON COV DAYS: 0

COINS DAYS: 0 LIFETIME RESERVE DAYS: 0 NO GRACE DAYS: EST AMT DUE:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR CODE OCCUR CODE DESCRIPTION DATE
TYPE ADMISSION CD: TYPE ADMISSION: SOURCE ADMIS CD: SOURCE ADMISSION:

ADDITIONAL INFORMATION:
INSURED NAME:
INSURED ADDRESS: [redacted]
INSURED CITY: [redacted] ST: [redacted] ZIP CODE: [redacted]
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION: Y

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

ADMIT DIAG CODE:	ADMT DIAG DESC:	
E-CODE :	E-CODE DESC:	
PRIN DIAG CODE: 6262	PRIN DIAG DESC: EXCESSIVE OR FREQUENT MENSTRUA	POA:

PRIN PROC CODE: DATE:

ATT PHYS NO: NAME: NPI: QUALIFIER:
OTH PHYS NO: 1821090515 NAME: GREEBON DARYL NPI: 1821090515 QUALIFIER:
OTH PHYS NO: NAME:
ID NO: REMARKS:
PAY-TO PROVIDER NPI: SERVICE FACILITY NPI: 1811988116

1 FLN/DCC 09195005199973 SSN: [redacted] SOURCE INDICATOR 6 VENDOR ID EN HOSPITAL BILLING DATE 07/14/09
PROCESS DATE: 07 14 09 PAYER ID: 87726 RTE IND: ATTCH: KEYER: 111111999 DT: 07 14 09

|PROVIDER NAME: AMBULATORY HEALTH SYSTEMS PROVIDER TEL:
|PROVIDER ADDRESS: 8409 PICKWICK LN, STE 238 PROVIDER SUB ID:
|PROVIDER CITY: DALLAS ST: TX ZIP CODE: 75225
|FAX NUM: COUNTRY CD: NPI: 1194986604

|EMC OFFICE NO: 0000|

|HEALTH PLAN ID:
|MEDICARE PROVIDER NO:
|MEDICAID PROVIDER NO:
|BLUE CROSS NO:
|FEDERAL TAX ID: 262791218

PATIENTS NAME:
[redacted]

|PATIENT CNTRL NO: [redacted] PATIENT SEX: F PATIENT DOB: [redacted] PAT MARITAL STAT:
|MEDICAL REC NO: 941 PAT EMPL STAT:

|1PAYER NAME: UNITED HEALTHCARE(METRAHE INSURED NAME: [redacted] PRIOR PAY AMT: 0.00
|SSN: [redacted] INSURED SEX: PAT REL: SPOUSE
|GROUP NAME: POLICY NO: 301000 ASSIGN BEN: Y

|2PAYER NAME: INSURED NAME: PRIOR PAY AMT: 0.00
|SSN: INSURED SEX: PAT REL:
|GROUP NAME: POLICY NO: ASSIGN BEN:
|CLAIM FILING INDICATOR: ICN/DCN NUMBER:

|3PAYER NAME: INSURED NAME: PRIOR PAY AMT: 0.00
|SSN: INSURED SEX: PAT REL:
|GROUP NAME: POLICY NO: ASSIGN BEN:
|CLAIM FILING INDICATOR: ICN/DCN NUMBER:

|TYPE BILL: SPEC FACIL/AMB SURG C/ADM-DSCH CL CD: 831 MOST COMM SEMIPVT RATE: PROC CD METHOD:

LINE #	REV CODE	RATE/ DATE	DESCRIPTION OR SERVICES	DAYS/ UNITS	CHARGE	HIC PIC	MOD1	MOD2	MOD DESCRIPTION CODE
001	0360	04/14		1	6500.00	58563			

AMT PAT PAID:	EST AMT DUE:	TOT CHARGE:	AMOUNT DUE:
0.00	0.00	6500.00	6,500.00

|TREATMENT AUTH NOS:

|STATMNT COV PER FROM: 04/14/09 THRU:

ADMISSION DATE: ADMISSION HOUR: DRG CD: 000
|PAT STATUS CD: PAT STATUS: DSCHG HR: COV DAYS: 0 NON COV DAYS: 0|

COINS DAYS: 0 LIFETIME RESERVE DAYS: 0 NO GRACE DAYS: EST AMT DUE:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR CODE OCCUR CODE DESCRIPTION DATE
TYPE ADMISSION CD: TYPE ADMISSION: SOURCE ADMIS CD: SOURCE ADMISSION:

ADDITIONAL INFORMATION:
INSURED NAME:
INSURED ADDRESS: [redacted]
INSURED CITY: [redacted] ST: [redacted] ZIP CODE: [redacted]
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION: Y

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

|ADMIT DIAG CODE: ADMT DIAG DESC:
|E-CODE : E-CODE DESC:
|PRIN DIAG CODE: 6262 PRIN DIAG DESC: EXCESSIVE OR FREQUENT MENSTRUA POA:

|PRIN PROC CODE: DATE:

ATT PHYS NO: NAME: NPI: QUALIFIER:
OTH PHYS NO: 1497738033 NAME: COULTER-SMITH BARBAR NPI: 1497738033 QUALIFIER:
OTH PHYS NO: NAME:
ID NO: REMARKS:
PAY-TO PROVIDER NPI: SERVICE FACILITY NPI: 1588868343

1 FLN/DCC 0825901341973 SSN: [redacted] SOURCE INDICATOR 6 VENDOR ID EN HOSPITAL BILLING DATE 09/15/08
PROCESS DATE: 09 15 08 PAYER ID: 87726 RTE IND: ATTCH: KEYER: 111111999 DT: 09 15 08

PROVIDER NAME: AMBULATORY HEALTH SYSTEMS PROVIDER TEL:	EMC OFFICE NO: 0000
PROVIDER ADDRESS: 8409 PICKWICK LN, STE 238 PROVIDER SUB ID:	
PROVIDER CITY: DALLAS ST: TX ZIP CODE: 75225	
FAX NUM: COUNTRY CD: NPI: 1194986604	

HEALTH PLAN ID:	
MEDICARE PROVIDER NO:	
MEDICAID PROVIDER NO:	
BLUE CROSS NO:	
FEDERAL TAX ID: 262791218	

PATIENTS NAME:
[redacted]

PATIENT CNTRL NO: [redacted]	PATIENT SEX: F PATIENT DOB: [redacted]	PAT MARITAL STAT:	
MEDICAL REC NO: 172	PAT EMPL STAT:		
1PAYER NAME: UNITED HEALTHCARE (METRAHE	INSURED NAME: [redacted]	PRIOR PAY AMT:	0.00
SSN: [redacted]	INSURED SEX: F	PAT REL: SELF	
GROUP NAME:	POLICY NO: 710712	ASSIGN BEN: Y CPT:	
2PAYER NAME:	INSURED NAME:	PRIOR PAY AMT:	0.00
SSN:	INSURED SEX:	PAT REL:	
GROUP NAME:	POLICY NO:	ASSIGN BEN: CPT:	
CLAIM FILING INDICATOR:	ICN/DCN NUMBER:		
3PAYER NAME:	INSURED NAME:	PRIOR PAY AMT:	0.00
SSN:	INSURED SEX:	PAT REL:	
GROUP NAME:	POLICY NO:	ASSIGN BEN: CPT:	
CLAIM FILING INDICATOR:	ICN/DCN NUMBER:		

TYPE BILL: SPEC FACIL/AMB SURG C/ADM-DSCH CL CD: 831 MOST COMM SEMIPVT RATE: PROC CD METHOD:

LINE #	REV CODE	RATE/ DATE	DESCRIPTION	DAYS/ UNITS	CHARGE	HIC PIC	MOD1	MOD2
001	0360	07/10	OR SERVICES	1	6500.00	58563		

MOD CODE: DESCRIPTION

AMT PAT PAID:	EST AMT DUE:	TOT CHARGE:	AMOUNT DUE:
0.00	0.00	6500.00	6,500.00

TREATMENT AUTH NOS:

STATMNT COV PER FROM: 07/10/08 THRU:

ADMISSION DATE: ADMISSION HOUR: DRG CD: 000
PAT STATUS CD: PAT STATUS: DSCHG HR: COV DAYS: 0 NON COV DAYS: 0

COINS DAYS: 0 LIFETIME RESERVE DAYS: 0 NO GRACE DAYS: EST AMT DUE:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR SPAN CODE1: OCCUR SPAN CODE2:
DATE FROM: THRU: DATE FROM: THRU:
OCCUR CODE OCCUR CODE DESCRIPTION DATE
TYPE ADMISSION CD: TYPE ADMISSION: SOURCE ADMIS CD: SOURCE ADMISSION:

ADDITIONAL INFORMATION:
INSURED NAME:
INSURED ADDRESS: [redacted]
INSURED CITY: [redacted] ST: [redacted] ZIP CODE: [redacted]
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION: Y

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

INSURED ADDRESS:
INSURED CITY: ST: ZIP CODE:
INSURED EMPLOYER NAME:
INSURED EMPLOYER ADDRESS: CITY: ST: ZIP CODE:
INSURED EMPLOYMENT STAT: RELEASE OF INFORMATION:

ADMIT DIAG CODE:	ADMT DIAG DESC:	
E-CODE :	E-CODE DESC:	
PRIN DIAG CODE: 6262	PRIN DIAG DESC: EXCESSIVE OR FREQUENT MENSTRUA	

PRIN PROC CODE: DATE:

ATT PHYS NO: NAME: NPI: QUALIFIER:
OTH PHYS NO: 1457389710 NAME: THURSTON JEFFRE NPI: 1457389710 QUALIFIER:
OTH PHYS NO: NAME:
ID NO: REMARKS:
PAY-TO PROVIDER NPI: SERVICE FACILITY NPI: 1982630604